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RESOLUTION FOR ELIMINATING RACIAL AND ETHNIC HEALTH DISPARITIES

Whereas SOPHE recognizes that the health and well-being of communities and the individuals within them is dependent not only on biological but also social and environmental factors and that under-represented communities of people in which health disparities are most evident have been historically silenced, ignored and their trust violated with regard to economic opportunity, environmental safety, health care access, health care service delivery and education and

Whereas Healthy People 2010 objectives for the nation recognizes that the systematic silencing, disregard, and violation of trust has a negative effect on the health and well-being of under-represented communities by continuing to perpetuate institutionalized oppressions and health disparities (1,2) and

Whereas, mortality from stroke is 80% higher in African Americans than Whites and the mortality rate for hypertension is three times higher for African Americans than Whites (1,2) and

Whereas, the mortality rate for all cancer is higher among African Americans than all other racial or ethnic groups; and the incidence of cervical and liver cancer in Asian Americans is as much as 5 times higher than other ethnic and racial groups (2,3,4) and

Whereas, African Americans and Hispanics make up 25% of the U.S. population, yet 55% of all AIDS cases; and Black and Hispanic women account for 77% of all female AIDS cases; and 57% and 24% of all pediatric AIDS cases occur in African Americans and Hispanics, respectively (2,5,6) and

Whereas, the infant mortality rates in African American and American Indian/Alaska Native infants are 1.5-2 times the rate of Whites; and mortality for African American women during childbirth is 3.5 times as high as White women (7,8,9,10) and

Whereas, African Americans and Native Americans are two times more likely to die from diabetes than Whites; and Hispanics are 2.5 times more likely to experience diabetes-associated renal failure than Whites (2,11) and

Whereas Native Americans are almost 2 times more likely to die from unintentional injury, followed by African Americans (2,12-17) and

Whereas, immunization rates are lowest among minorities, children from lower income families, and children with less educated parents (18-24) and

Whereas, the rate of non-elderly Hispanics who lack health insurance is two times the national average; and only 20% of Native Americans have access to the Indian Health Service (2,25-31) and

Whereas, African Americans, Hispanics, Native Americans, and people with low socioeconomic status are less likely to own or have access and knowledge and skills to use computers (2,32) thereby decreasing their access to the latest health information and access to medical records and

Whereas, underrepresented minorities represent over 25% of the U.S. population, but account for only 10% of all health professionals, and affirmative action programs in higher education have been under attack or dismantled, and barriers to the recruitment and retention of qualified persons representing under-represented groups into the health professions and schools of public health, medicine, nursing etc. are considerable, and these groups can play an indispensable role in helping to reduce health disparities by working in underserved communities (29,33-44).

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Now therefore be it resolved that SOPHE:

INTERNAL ACTIVITIES:

- (1) Assess possible means by which SOPHE contributes to exclusion, discrimination or oppression of under represented groups in its operations, policies, and actions.
- (2) Initiate an organizational wide educational campaign to eliminate operations, policies, and processes that exclude and discriminate against under represented populations.
- (3) Through the Open Society Commission examine ways in which SOPHE can more vigorously participate in efforts toward an open and just society both within our own organization and in collaboration with others.
- (4) Support professional training opportunities to increase cultural competency of public health education and health care professionals.
- (5) Initiate scholarship opportunities for African Americans, Hispanics, and Native Americans, Asian and Pacific Islanders, and Alaska Natives SOPHE members to promote their public health education professional development, education and training.
- (6) Commit resources and efforts to developing and implementing effective methods of recruiting students of color, and other underrepresented groups into SOPHE.

EXTERNAL ACTIVITIES:

(1) Support advocacy efforts for:

- Increased funding opportunities for the identification of data for under represented racial and ethnic groups as well as the provision and evaluation of programs to address the underlying determinants of health disparities.
- Increased funding opportunities for recruitment and training public health educators and other health care professionals representing under represented groups.

(2) Improve professional education and development opportunities by:

- Seeking funds from Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA) or other potential parties to examine the proportion of students in professional preparation programs in health education that represent minorities according to either race or ethnicity.
- Advocating for the hiring and promotion of racial and ethnic minority faculty in professional preparation programs in health education

(3) Collaborate with national initiatives to eliminate racial and ethnic health disparities such as the President's Initiative on Race, the NIH National Center on Minority Health and Health Disparities, HRSA's Office on Minority Health and, the DHHS Office on Minority Health.

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**SUPPORTING INFORMATION FOR THE
Resolution For Eliminating Racial and Ethnic Health Disparity**

Disparities in heart disease

Sources:

(1) American Heart Association, High Blood Pressure Fact Sheet, http://www.americanheart.org/hbp/phys_stats.html, 2000.

(2) US Department of Health and Human Services, (2000) Healthy People 2010. Washington, DC: US Government Printing Office.

- The heart disease death rate has been consistently higher in males than in females.
- The heart disease death rate has been higher in the African American population than the white population.
- In the 1970's, African American females experienced the greatest decline in CHD (Chronic Heart Disease)
- This decline disappeared in the 1980's, when rates of decline for white males and females exceeded those for African American males and females; African American females had the lowest rate of decline.
- In the 1980's, males had a steeper rate of decline than females
- Between 1980 and 1995, the percentage declines were greater in males than in females.
- Between 1980 and 1995, the percentage declines were greater in whites than in African Americans.
- In 1995, the age-adjusted death rate for heart disease was 42 percent higher in African American males than in white males
- In 1995, the age-adjusted death rate for heart disease was 65 percent higher in African American females than in white females
- The age-adjusted death rate was almost twice as high in males as in females.
- Females, in general, have poorer outcomes following a heart attack than do males
- 44 percent of females who have a heart attack die within a year, compared with 27 percent of males.
- Older females who have heart attacks are twice as likely as older males to die within a few weeks.
- Complications are more frequent in females than in males after coronary intervention procedures, such as angioplasty or bypass surgery.
- The number of existing cases of high blood pressure (hypertension) is nearly 40 percent higher in African Americans than in whites (an estimated 6.4 million African Americans have hypertension).
- The effects of hypertension are more frequent and severe in the African American population.

(2) Disparities in cancer

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Sources:

(2) US Department of Health and Human Services. (2000) Healthy People 2010. Washington, DC: US Government Printing Office.

(3) National Cancer Institute, SEER Cancer Statistics Review, 1973-1996, 1999.

(4) Haynes MA. And Smedley BD. (Eds.) The burden of cancer among ethnic minorities and medically underserved populations. In: The Unequal Burden of Cancer. An Assessment of NIH Research and programs for Ethnic Minorities and the Medically Underserved. 199. Washington DC: National Academy Press.

- The incidence of breast cancer in African American women is lower than in whites but mortality is greater.
- The prostate cancer mortality rate in African American men is two times that of white men; and the incidence of colorectal cancer is higher in African American men than in white men and women.
- Vietnamese women are 5 times more likely to suffer from cervical cancer than White women.
- Asian American men are 2-3 times more likely to get liver cancer than all other ethnic and racial groups.
- Those with 12 years or less of education are at least 3 times more likely to die from cancer as those with a college education.
- The rate of death from lung cancer is 2 times higher in males than in females.
- The mortality rate for all cancer is higher among African Americans than all other racial or ethnic groups.

(3) Disparities in AIDS

Sources:

(5) Murrain M. Differential survival in Blacks and Hispanics with AIDS. *Ethnicity & Health*. 1996;1(4):373-382.

(6) Centers for Disease Control and Prevention. HIV Surveillance Report. www.cdc.gov/hiv/stats/hasrlink.htm. 2000.

(2) US Department of Health and Human Services. (2000) Healthy People 2010. Washington, DC: US Government Printing Office.

- The prevalence of AIDS in African-Americans is approximately 8 times the rate for whites.
- The prevalence of AIDS in Hispanics is approximately 3.4 times the rate for whites.
- AIDS is the leading cause of death for African-American men.
- AIDS is the 2nd leading cause of death for African-American women.
- Americans in rural areas are experiencing the largest increases in the incidence of HIV.
- AIDS is the leading cause of death for all blacks aged 25-44.
- Males represent 83% of all AIDS cases.

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(4) Disparities in infant mortality

Sources:

- (7) Office of Minority Health, Race and Health. Infant Mortality: How to Reach the Goals (underlined) <http://www.raceandhealth.omhrc.gov>.
- (8) Monthly vital statistics, 46(12)(s), August 27, 1998.
- (9) Hill, W.C. (1999). Jumping the broom toward eliminating health disparities: Presidential address. *American Journal of Obstetrics and Gynecology*, 180(60),1315-1321.
- (10) Singh, G.K.& Yu, S.M. (1995). Infant Mortality in the United States: Trends, Differentials, and Projections, 1950 through 2010. *American Journal of Public Health*, 85(7), 957-964.
- Black and Puerto Rican infants are delivered low birthweight (less than 2500g) at 1.5-2 times the rate of white infants.
 - Black and American Indian/Alaska Native infants are 2.5 – 3.5 times more likely to die from Sudden Infant Death Syndrome (SIDS) than White infants. The rate of SIDS deaths among Blacks children is 2X that of White children, 3X that of Hispanic children.
 - SIDS was the second major killer of black babies in 1991.
 - Black infants are born early almost twice as early (preterm birth) as White infants.
 - Fetal mortality rates (associated with maternal complications of pregnancy; also included in infant mortality rates) among blacks was 12.7 per 1000 live births in 1995, 1.8 times that of the population. This gap has continued to widen since 1995.
 - In 1996, early prenatal care was received by 84% of white pregnant women, compared with 71% of black and Hispanic women.
 - Leading cause of infant death among Black women in 1991 was premature births and low birthweight (less than 2500 grams). It accounted for every 1 in 6 black infant deaths.
 - Despite overall reductions in infant mortality, the race disparity not only has persisted, but has increased over time.
 - The risk of mortality is 2.2 times higher for black infants than for white infants.
 - The United States ranks 24th in infant mortality compared with other industrialized nations.
 - The Black infant death rate was 14.2 per 1000 live births in 1996 compared with the White infant death rate of 6.0. This is nearly 2.5 times greater.
 - American Indian and Hispanic infant mortality rate is also 2-3 times greater than for Whites.
 - Major leading causes of death for Black infants include:
 - **short gestation (preterm birth)**. A much higher incidence of preterm birth occurs among blacks than whites (17.7 compared with 9.7 percent.)
 - **low birthweight.**
 - **respiratory stress syndrome.**

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- **infections.**
- **SIDS.** The rates are 3-4 times as high for some American Indian and Alaska Native populations.

(5) Disparities in diabetes

Sources:

- (11) Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Public Health Resource, <http://www.cdc.gov/diabetes/statistics/surv199/chap5/chapter5Intro.htm>, 2000.
 - (2) US Department of Health and Human Services, (2000) Healthy People 2010. Washington, DC: US Government Printing Office.
- Racial and ethnic communities, including African Americans, Hispanics, American Indians, and certain Pacific Islander and Asian Americans as well as economically disadvantaged or older Americans, suffer disproportionately compared to white populations.
 - The relative number of persons with diabetes in African American, Hispanic, and American Indian communities is one to five times greater than in white communities.
 - African-Americans are two times more likely to die from diabetes than their white counterparts
 - Hispanics are two and a half time more likely to experience diabetes-associated renal failure than their white counterparts.
 - Mortality rates per 100,000 by race and ethnicity:
 - Whites 15.9
 - African American 39.1
 - Asian Pacific Islander 12.9
 - Hispanic 25.6

(6) Disparities in unintentional injuries

Sources:

- (12) Christoffel T., Gallagher SS. Injury Prevention and Public Health. Practical Knowledge, Skills, and Strategies. 1999. Gaithersburg: Athens Publications.
- (13) National Safe Kids Campaign. Children at Risk. 1999. <http://www.safekids.org>.
- (14) Sadowski LS. Munoz SR. Nonfatal and fatal firearm injuries in a rural county. JAMA. 1996;275(22):1762-64.
- (15) Kellerman AL, Rivara FP. Lee RK. Banton JG, Cummings P, Hackman B, Somes G. Injuries due to firearms in three cities. The New England Journal of Medicine. 1996;336(19):1438-44.

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(16) Overpeck MD, Jones DH, Trumble AC, Scheidt PC, Bijur PE. Socioeconomic and racial/ethnic factors affecting non-fatal medically attended injury rates in US children. *Injury Prevention*. 1997;3:272-76.

(17) Johnson SJ, Sullivan M, Grossman DC. Injury hospitalization among American Indian youth. *Injury Prevention*. 1999;5:119-23.

(2) US Department of Health and Human Services. (2000) *Healthy People 2010*. Washington, DC: US Government Printing Office.

- Unintentional injury is defined as injury that occurs over a relatively short period of time -- seconds or minutes and the harmful outcome is not sought. This type of injury results from: (1) a form of physical energy in the environment (kinetic, chemical, thermal, electrical, ionizing radiation) or (2) physical activity gone amiss (bicycle injuries, drowning.) Examples include: Motor vehicle injuries, falls, poisoning, fires and burns, drowning, aspirations, sports injuries.
- Intentional injuries are intentional acts that lead to injury. Often death is intended. Violence is included. Examples include: Self-inflicted violence (suicide or attempts), homicide, nonfatal assaultive violence, violent exploitation of women (spousal abuse, rape, sexual assault,), child or elder abuse.
- Unintentional death rates (per 100,00) by race or ethnicity are as follows: American Indians/Alaska Natives 62.7, Blacks 40.9, Whites 34.3, Hispanics 30.1, Asian/Pacific Islanders 20.9.
- Children from low-income families are: twice as likely to die in a motor vehicle crash, four times more likely to drown, and five times more likely to die in a fire.
- Risk factors for unintentional injuries include: single parent households, lack of education/maturity, young maternal age, multiple siblings, substandard or overcrowded housing, lack of safe recreational facilities, proximity of housing to busy streets, inadequate care or supervision, increased exposure to physical hazards, lack of use of safety devices due to reduced income, lack of transportation, lack or control over housing conditions.
- Among Native Americans, there are disproportionately higher death rates from motor vehicle crashes, residential fires, and drowning; death rates are 1.75 times that of the overall population; unintentional injury is the second leading cause of death for males and third for females in all age groups; risk factors include rural or isolated living, minimal emergency medical services, and distance to sophisticated emergency care.
- Blacks are twice as likely to die from unintentional injuries than Whites.
- In every age group, males have a higher risk of death and injury than females and drowning rates are almost 2-4 times greater for males than females.
- Homicides rates (per 100,000) among males and females 15-24 years of age are African Americans 74.4, Hispanics - 34.1, and Whites - 5.4.
- Homicide is the second leading cause of death in all young people 15-24 and leading cause of death for African Americans in this age group.

(7) *Disparities in immunization rates*

Sources:

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- (18) Carter/Bumpers Campaign for Early Immunization. Every Child by Two. <http://www.ecbt.org>.
- (19) Kenyon TA, Matuck MA, Stroh, G. Persistent low immunization coverage among inner-city preschool children despite access to free vaccine. *Pediatrics*. 1998;101(4):612-616.
- (20) CDC. Reported vaccine-preventable diseases -- United States, 1993, and the Childhood Immunization Initiative. *MMWR* 1994; 43:57-60.
- (21) National Center for Health Statistics. Health, United States, 1998, with socioeconomic status and health chart book. Hyattsville, Maryland: US Department of Health and Human Services, CDC, National Center for Health Statistics, 1998.
- (22) CDC. Recommendations of the Advisory committee on Immunization Practices: programmatic strategies to increase vaccination rates -- assessment and feedback of provider-based vaccination coverage information. *MMWR* 1996;45:219-20.
- (23) CDC. Status report on the Childhood Immunization Initiative: national, state, and urban area vaccination coverage levels among children aged 19-35 months -- United States, 1996. *MMWR* 1997;46:657-64.
- (20) CDC. Reported vaccine-preventable diseases -- United States, 1993, and the Childhood Immunization Initiative. *MMWR* 1994;43:57-60.
- (24) CDC. Immunization schedule -- United States, 1998. *MMWR* 1998;47:8-12.
- (23) CDC. Vaccination coverage by race/ethnicity and poverty level among children aged 19-35 months -- United States, 1996. *MMWR* 1997;46:963-9.
- the rates of childhood immunization are lower in Black and Hispanics than in Whites.
 - the rates of childhood immunization are lower in children living in poverty and in those who use public providers.
 - adult immunizations for influenza are lower in Hispanics and Blacks than in Whites.
 - In 1998, national coverage estimates for DTP series were:
 - 80.5% among Hispanics
 - 86.6% among non-Hispanic Whites
 - 77.3% among non-Hispanic Blacks
 - 82.9% among non-Hispanic Native Americans
 - 89.1% for non-Hispanic Asian/Pacific Islander children.
 - National coverage estimates for Polio series were
 - 88.9% among Hispanics
 - 92.2% among non-Hispanic Whites

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- 87.8% among non-Hispanic Blacks
- 85.1% among non-Hispanic Native Americans
- 93.4% among non-Hispanic Asian/Pacific Islander children.
- National coverage estimates for MCV were:
 - 91.2% among Hispanics
 - 93.3% among non-Hispanic Whites
 - 88.9% among non-Hispanic Blacks
 - 91.4% among non-Hispanic Native American
 - 92.4% among non-Hispanic Asian/Pacific Islander children.
- National coverage estimates for HiB series were
 - 91.7% among Hispanics
 - 95.0% among non-Hispanic Whites
 - 90.1% among non-Hispanic Blacks
 - 90.0% among non-Hispanic Native Americans
 - 92.3% for non-Hispanic Asian/Pacific Islander children.
- National coverage estimates for HepB series were:
 - 85.7% among Hispanics
 - 88.3% among non-Hispanic Whites
 - 83.7% among non-Hispanic Blacks
 - 81.6% among non-Hispanic Native Americans
 - 89.0% for non-Hispanic Asian/Pacific Islander children.
- National coverage estimates for varicella vaccine were
 - 46.9% among Hispanics
 - 41.9% among non-Hispanic Whites
 - 42.4% among non-Hispanic Blacks
 - 28.0% among non-Hispanic Native Americans
 - 52.6% for non-Hispanic Asian/Pacific Islander children.
- National coverage estimates for the 4:3:1:3 series among racial/ethnic groups
 - 82.2% for non-Hispanic Whites (state range 73.7% -92.7%)
 - 75.3% for Hispanics (state range 67.3%-85.9%)
 - 72.9% for non-Hispanic Blacks (state range 52.2%-94.1%).
- National coverage estimates for the 4:3:1:3 series by geographic location.
- Non-Hispanic Native American children, coverage estimates for 4:3:1:3 in census divisions were 72.8%, 74.2%, 80.2%, and 81.1%, for the Pacific, Mountain, West North Central, and West South Central divisions, respectively.
- For non-Hispanic Asian/Pacific Islander children census division coverage ranged from 68.1% to 90.7% in the six divisions with sufficient sample size.
- In selected urban areas, 4:3:1:3 coverage for Non-Hispanic White children ranged from 64.9% to 92.2%; only 2 urban areas exceeded 90%.
- For non-Hispanic Black children, 4:3:1:3 coverage ranged from 51.7% to 92.5%; only 2 urban areas exceeded 90%.
- For Hispanic children, 4:3:1:3 coverage in selected urban areas ranged from 57.3% to 90.9%; only 1 urban area exceeded 90%.
- At the national level, vaccination coverage for the 22% of children living below the poverty level lagged behind coverage for all U.S. children.

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- For coverage with Polio series, the difference between all children and those living in poverty was only 0.8%.
- For the combined 4:3:1:3 series, the 4:3:1 series, and DTP series, children living in poverty had coverage levels 5, 4, and 4 percentage points lower than all U.S. children, respectively.
- Both vaccination coverage among children living in poverty and the proportion of children living in poverty varied widely by state. Among children living in poverty coverage for:
 - DTP series ranged from 67.9% to 96.3%; only 5 states achieved coverage of at least 90%.
 - For Polio series, coverage ranged from 80.6% to 98.6%; 25 states achieved coverage of at least 90%.
 - MCV ranged from 80.1% to 99.0%; 25 states achieved coverage of at least 90%.
 - HepB series ranged from 79.3% to 99.6%; 29 states achieved coverage of at least 90%.
 - HepB series vaccine coverage ranged from 73.5% to 95.1%; only 14 states achieved coverage of at least 90%.
 - Varicella ranged from 32.8% to 66.6%.
- In selected urban areas, coverage with DTP series among children living in poverty ranged from 59.1% to 94.1%; only 3 areas achieved at least 90% coverage. For Polio series, coverage ranged from 70.8% to 100%; 12 areas achieved coverage of at least 90%. For MCV ranged from 73.1% to 98.0%, 11 areas achieved coverage of at least 90%. For HepB series, coverage ranged from 80.1% to 100%; 11 areas achieved coverage of at least 90%. For HepB series, coverage ranged from 69.6% to 97.2%; only 5 areas achieved coverage of at least 90%. Coverage for VAR ranged from 33.2% to 80.4%.
- At the national level, coverage with the 4:3:1:3 combined series of vaccines among children immunized by public providers was 3.8 percentage points lower than among children immunized by private providers.
- In States, coverage among children immunized by public providers ranged from 61.6% to 90.0%; coverage among children immunized by private providers ranged from 65.4% to 92.5%.
- In selected urban areas, coverage among children immunized by public providers ranged from 64.5% to 92.8%; coverage among children immunized by private providers ranged from 60.9% to 89.1%.
- Nationwide in 1997, 70.5% adults had not had a flu shot in the past 12 months. And 83% said that they had never had a Pneumonia vaccination. Pneumococcal vaccination rates: Whites 47.3%; Hispanics 34.1%; Blacks 29.7%.

(8) Disparities in access

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Sources:

- (2) US Department of Health and Human Services. (2000) Healthy People 2010. Washington, DC: US Government Printing Office.

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- (25) Wright RA. Community-oriented primary care: The cornerstone of health care reform. *J Am Medical Association* 269(19):2544-2547, 1993.
- (26) Carrasquillo O, Carrasquillo AI, Shea SS: Health insurance coverage if Immigrants living in the United States: Differences by citizenship status and country of origin. *Am J Public Health* 90(6):917-923, 2000.
- (27) Friedrich MJ: Medically underserved children need more than insurance card. *J Am Medical Association* 283(23):3056-3057, 2000.
- (28) Komaromy M, Grumbach K, Drake M, Vranizan K, Lurie N, Keane D, Bindman AB. The role of Black and Hispanic physicians in providing health care for the underserved populations. *New England Journal of Medicine*. 1996;334(2): 1305-1310.
- (29) Xu G, Fields SK, Laine M, Veloski JJ, Barzansky B, Martini CJM. The relationship between the race/ethnicity of generalist physicians in providing their care for the underserved populations. *AJPH*. 1997;87(5):817-822.
- (30) House JS, Kessler RC, Herzog AR. Age, socioeconomic status, and health. *The Milbank Quarterly*. 1990;68(3):383-411.
U.S. Department of Health and Human Services. Health, United States, 1998 with Socioeconomic Status and Health Chartbook. Hyattsville, MD: National Center for Health Statistics, 1998.
- (31) Hall AG, Collins KS, Glied S. Employer sponsored health insurance: Implications for minority workers. New York: New York. The Commonwealth Fund, February 1999.
- In 1988, 44.3 million people lacked health insurance (over 16%)
 - In 1997, 84% people in America had a usual source of care.
 - Hispanics, young adults and uninsured persons are least likely to have a usual source of care.
 - Hispanics and people with <12 years of education are least likely to have a usual primary care provider.
 - In 1997, among non-elderly Hispanics, 31% lacked health insurance coverage, which is double the national average.
 - Mexican-American had one of the highest uninsured rates (35%.)
 - For adults less than 65 years, 33% of those below the poverty level are uninsured and lack a source of ongoing care.
 - 82% of employer sponsored insurance plans include coverage for childhood immunization.
 - 90% of employer sponsored insurance plans include Pap tests and mammograms.
 - The uninsured have low numbers of office visits, are less likely to be immunized, receive prenatal-care, have their blood pressure checked or seek care for serious symptoms.

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- The majority of uninsured people are young, minority, poor and employed by small businesses.
- Among immigrant non-citizens the following proportions lacked health insurance: 43% children and 12% elders, compared with 14% non-immigrant children and 1% non-immigrant elders.
- Only 50% non-citizen full-time workers have employer-sponsored health coverage – compared with 81% of non-immigrant full time workers.⁹
- 71 million people live in the 2700 federally named health professional shortage areas (HPSA) in the US.
- 71% of the HPSA's are in rural areas.
- 21 million are at risk of having no health care or have structural access issues.¹⁰
- In general, individuals with higher incomes have lower mortality rates than poor individuals.
Minorities who hold comparable jobs as non-minorities have a lower rate of insurance coverage.

(9) Digital divide

Sources:

(32) Eng TR, Maxfield A, Patrick K, Deering M, Ratzan SC, Gustafson, DH: Access to health information and support: A public highway or a private road?. *J Am Medical Association* 280(15):1371-1375, 1998.

(2) US Department of Health and Human Services. (2000) Healthy People 2010. Washington, DC: US Government Printing Office.

- People with low socioeconomic status are least likely to own or have access to a computer. For example, only 7% of U.S. households that have incomes less than \$20,000 have Internet access.¹
- Low SES, rural households, African Americans, and Hispanics people are less likely to have access or own a computer than other groups.
- 38% of US households with incomes \geq to \$50,000 have Internet access, while only 7% of US households with incomes \leq to \$20,000 have Internet access.

(10) Disparities in public health and medical care providers

Sources:

(33) Zimmerman MK: Status Report on Women's Health in Medical Education and Training. [Online] <http://www.hc-sc.gc.ca/canusa/papers/usa/english/training.htm>.

(34) Health Care Fairness Act (H.R.3250 and S.1880) [Online]. Available: <http://www.amsa.org/lad/fairness.html>.

(35) Bureau of Health Professions Health Resources and Services Administration. United States Health Workforce Personnel Factbook. [Online]. Available: <http://bhpr.hrsa.gov.healthworkforce.factbook.htm>. 2000.

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- (36) Minorities in Medicine. Rockville, MD: Council on Graduate Medical Education, Twelfth Report, 1998.
- (37) Chavkin W. Topic for our times: Affirmative Action and Women's Health. *American Journal of Public Health* 1997;87(5):732-734.
- (38) Libby DL, Aho Z, Kindig DA. Will minority physician supply meet U.S. needs? *Health Affairs*. 1997;16(4):205-214.
- (39) Nickens HW, Cohen J. On Affirmative action. *JAMA*. 1996;275(7):572-574.
- (40) Trevino FM. The representation of Hispanics in the health professions. *Journal of Allied Health*. 1994;23(2):65-77.
- (41) Keith SM, Bell RM, Swanson AG, and Williams AP. Effects of affirmative action in medical schools: A study of the class of 1975. *New England Journal of Medicine*. 1985;313(24):1519-1525.
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- (43) Komaromy M, Grumbach K, Drake M, Vranizan K, Lurie N, Keane D, Bindman AB. The role of Black and Hispanic physicians in providing health care for the underserved populations. *New England Journal of Medicine*. 1996;334(2):1305-1310.
- (29) Xu G, Fields SK, Laine M, Veloski JJ, Barzansky B, Martini CJM. The relationship between the race/ethnicity of generalist physicians in providing their care for the underserved populations. *AJPH*. 1997;87(5):817-822.
- (44) Fang D; Moy E, Colburn, Hurley, J. Racial and ethnic disparities in faculty promotion in academic medicine. *JAMA*. 2000;284(9):1085-1092
- African Americans account for approximately 13% of the population but only 3.7% of practicing physicians.
 - Only 3.3% of all U.S. medical school faculty members are underrepresented minorities and only 1% of full professors are minorities. Minorities are also underrepresented in medical practice.
 - Women continue to be underrepresented in medical education and practice.
 - In 1994 African-Americans, American Indians, Alaska Natives, Hispanics and Asians combined represented 31% of entering medical school classes; over 50% of those were Asian.
 - In 1997, 30% of underrepresented minority assistant professors and 36% of underrepresented minority associate professors had been promoted, while 37% of Asian Pacific Islander (API) assistant professors and 50% of API associate

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- professors, and 46% of White assistant professors and 50% of White associate professors were promoted.
- In 1997 the percentage of underrepresented minorities (African Americans, Mexican Americans, Puerto Ricans, American Indians and Alaska Natives) appointed to assistant professorships in U.S. Medical Schools was only 4.6%.
 - In Schools of Public Health in 1997 there were only 25 tenured African American faculty members.
 - In 1994-95 13.8% of all graduates of U.S Schools of Public Health were African American, Hispanic and American Indian, while 8.6% of graduates were Asian.
 - Affirmative action programs that have been dismantled or under attack include Texas, Hopwood decision (1998), Calif. Proposition 209 (1998), Florida (2000.)
 - Minority and female physicians are more likely to care for minority, poor, sicker, Medicaid, and uninsured patients than non-minority physicians.

(11) Disparities in research

- There has been no substantial increase in the enrollment rate for women in the past 30 years.
- Women and minorities are underrepresented in research studies.
- Available data indicate important health disparities between minorities and the general population, but racial and ethnic data are necessary to address the minority population's special health and social service needs.
- Consistent reliable racial and ethnic data are needed to develop and implement effective prevention, intervention, treatment, and other needed health programs, policies and services.

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Sources:

Health Care Fairness Act (H.R.3250 and S.1880) [Online]. Available:
<http://www.amsa.org/lad/fairness.html>.

U.S. Department of Health and Human Services. Office of Minority Health.